Division of Medical Assistance Non State ICF-MR Assessment Procedures

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A. Overview

Effective July 1, 2004 a provider assessment for all Non State-Owned Intermediate Care Facility for the Mentally Retarded (ICF-MR) is being implemented based on the approval received from CMS March 21, 2005. This assessment is for the primary purpose of providing the ICF-MR providers with a needed rate increase in order for them to hire and retain adequate staff to provide direct care services to Medicaid clients. This assessment will increase both the direct and indirect rates per day and will involve the payment of a daily occupied bed day provider assessment. The provider assessment will be calculated and due on a monthly basis. The complete monthly provider assessment fee process is explained later in the monthly provider tax fee payment process section.

If you have any questions or concerns, please call the Division of Medical Assistance, Rate Setting Section at 919-855- 4200. These procedures are also posted on the Division of Medical Assistance (DMA) web site at the following address:
http://www.dhhs.state.nc.us/dma/icfmr/icfmr.html

Assessment Effect on Rates
The Non State ICF-MR assessment will involve the payment of a daily occupied bed day provider assessment fee of $9.33 on all non-Medicare bed days. It will also involve a total rate increase of $25.53 which is a $23.73 increase to the facility's direct rate and a $1.80 increase to the facility's indirect rate For example: if a provider's direct rate is $121.00 then their direct rate will increase to $144.73. Additionally if their indirect rate is $65.96 then it will increase to $67.76. Then with the ICF-MR provider's new indirect rate being $67.76 and their direct rate being increased to $144.73 the total per diem rate increase will be $212.49. Any ICF-MR providers that have had a rate increase in the SFY 05 rate increase will have this taken into consideration during this rate adjustment.

ICF-MR Provider Agreement Addendum
All ICF-MR providers will be required to complete and sign a provider agreement addendum. This provider addendum will be replacement of page 3 of your current provider agreement. Please note the addition of items 7 & 8 under section C. Complete, sign and return the provider agreement addendum to **DMA Rate Setting Section, Attention: Mishawn Davis, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501.** Completed and signed forms are due no later than April 30, 2005. Failure to submit the addendum to the provider agreement may result in the Division of Medical Assistance taking action with respect to your reimbursement rate and/or retroactive payment. A penalty may be enforced until the provider agreement is received. As stated in Attachment 4.19-D .0306 (e) (5) " The State may withhold up to twenty (20%) percent per month of a provider's payment for failure to file a timely cost report or other relevant information related to a facility's operation and requested by the Division of Medical Assistance". Please refer to your State Plan for complete guidelines under Payment Assurances.

Cost Reports
The total amount paid through the ICF-MR Assessment will be an allowable cost on the Cost Report. This allowable cost is effective for the SFY beginning July 1, 2004. The cost report will be modified to include a cost center line for the provider assessment fee on the Schedule A. The Cost Report will also, be modified to include a Piedmont revenue line on the Schedule G. The Piedmont Medicaid days will also need to be broken out on the Cost Report on the Facility Statistics and Monthly Census Summary Schedules so the costs associated with clients with a county of residence in Piedmont 5 county area can be allocated to these days. The Piedmont costs and days will not be cost settled. All ICF-MR Providers including providers with occupied bed days in the Piedmont counties of residency will submit cost reports based on the customary

process. Individual Cost Reports are submitted to DMA, Rate Setting Section and combined Cost Reports are submitted to DMA, Audit Section.

Cost Settlements

The cost settlement process has not changed. ICF-MR providers will retain all of the Medicaid payments as long as their direct costs per day exceed the direct rate paid as validated by a desk audit of the cost report. If the providers direct care costs per day exceed the direct care rate paid per day, the provider will not receive further payment. If the direct care costs per day are less than the direct rate paid per day, providers will need to pay the state back the overpayment amount. Please refer to Attachment 4.19-D .0304 (i) for a complete explanation. Any ICF-MR Medicaid paid days a facility has for clients with a county of residence in the 5 Piedmont counties will not be cost settled. These days will need to be separately broken out on the Cost Report and used as a basis of allocating the costs associated with the Piedmont Medicaid days and these days and costs will not be cost settled.

Rate Appeals

The Division of Medical Assistance shall consider rate appeals for ICF-MR providers based on the usual process. Please see attachment 4.19-D .0308 for the complete rate appeals procedure. Please keep in mind the direct care rate is subject to cost settlement. If the direct care costs per day are less than the direct rate paid per day, providers will need to pay the state back the overpayment amount. Please refer to Attachment 4:19-D .0304 (i) for a complete explanation.

Piedmont Area Counties

ICF-MR providers having clients with a county of residence of Cabarrus, Davidson, Rowan, Stanly, and Union counties in North Carolina will need to separately track these Medicaid occupied bed days. The facility will still pay an assessment fee on these non-Medicare paid days to the DHHS Controllers Office. The rate paid for these clients will be negotiated between Piedmont and the facility. Piedmont has had an adjustment made to their capitated rate which includes the assessment fee. Piedmont will manage the assessment for these 5 counties and will determine the amount of the rate increase each will receive. Piedmont does not plan to cost settle. Piedmont will begin operation as a capitated program April 1, 2005.

B: The ICF-MR Assessment Retroactive Payment Process

The Division of Medical Assistance, Rate Setting Section will calculate retroactive payments due to the ICF-MR Assessment implementation back to the July, 1 2004 date. All ICF-MR providers will be required to complete, sign and return an updated ICF-MR Provider Agreement addendum before any retroactive payments will be processed. Completed and signed forms are due no later than April 30, 2005. Please send your addendum to your provider agreement to DMA Rate Setting Section, Attention: Mishawn Davis, 2501 Mail Service Center, Raleigh, North Carolina 27699-2501.

Retroactive payments will be processed once DMA, Rate setting receives the Provider Agreement addendum. All retroactive payments will be made through the Controllers Office not EDS. ICF-MR providers will be required to submit an ICF-MR retroactive assessment worksheet and payment within 30 days of receiving their retroactive payment checks. It is critical that these retroactive payments be submitted on a timely basis. A sample and instructions of the ICF-MR Retroactive Assessment Worksheet follows. As stated in Attachment 4.19-D .0306 (e) (5) " The State may withhold up to twenty (20%) percent per month of a provider's payment for failure to file a timely cost report or other relevant information related to a facility's operation and requested by the Division of Medical Assistance". Please refer to your State Plan for complete procedure under Payment Assurances.

If you have any questions or concerns, please call the Division of Medical Assistance, Rate Setting Section at 919-855-4200.

C. Sample and Instructions for the Retroactive Payment Assessment Worksheet

ICF-MR Retroactive Assessment Worksheet

ICF Provider Name:

Medicaid ICF-MR Provider Number

Facility Administrator/Officer Signature / Title (Validation of Amounts)

Date

Print Name

Telephone #

Email Address

	(A)	(B)	(C)	
	Medicaid Occupied Bed Days(Less Piedmont)	Private Days (non-Medicaid, non-Medicare) Occupied Bed Days	Total Days (A+B)	
July 2004				
August 2004				
September 2004				
October 2004				
November 2004				
December 2004				
January 2005				
February 2005				
March 2005				
Totals				(D)
			$9.33	(E)
				(F)

INSTRUCTIONS:

For all of the days figures requested, only report ICF-MR Occupied bed days. Separate any Piedmont Counties of Residence Medicaid occupied bed days.

Column A: Enter the number of Medicaid (non-Piedmont) days for each of the months specified. Enter the number of ICF-MR occupied bed days paid or payable by North Carolina Medicaid through the ICF-MR program reimbursement for the specified month. Include any Medicaid pending days (note these figures may not agree with EDS figures).

Column B: Enter the number of Private days for each of the months as specified. Enter the number of any ICF-MR occupied bed days not paid or payable by either Medicare or Medicaid as an ICF-MR facility day. This includes all ICF-MR Bed days that are paid for privately by the patients with cash or private long care insurance.

Item C: Add the amount from columns A and B and enter the result in column C for each of the listed months.

Item D: Sum amounts in column C and enter the total here

Item E: The daily provider assessment $9.33 amount.

Item F: Multiply item D by item E and enter the result here. This is the retroactive assessment amount that is to be paid to the Division of Medical Assistance no later than **June 1, 2005.**

D. The Monthly Provider Assessment Payment Process

The provider assessment will be calculated and paid on a monthly basis for non-state owned ICF-MR providers. The assessment will be paid on all occupied bed days. Any ICF-MR providers with clients having a county of residence in one of the 5 Piedmont counties will submit the monthly assessment fee statement and pay a provider assessment on these days as well to DHHS. The Piedmont Medicaid days will need to be separately reported on the assessment form. The provider tax assessment fees must be received by the 15th of each following month. For example: for the occupied days of April the assessment fees would be due by May 15th. Non-state ICF-MR providers will be required to remit 2 copies of the monthly assessment statement when they remit their provider assessment fees based on total number on occupied bed days. Providers should remit all assessment forms with payments to **DHHS Accounts Receivable, 2022 Mail Service Center, Raleigh, NC 27699**. To avoid any delay do not send any payments to the Division of Medical Assistance.

For the first month, providers who have failed to submit an assessment statement and payment will receive a courtesy call from DMA to determine where the break-down in communication may have occurred. If the ICF-MR provider does not remit the provider tax and statement by the 15th of the following month a penalty may be enforced until the assessment fees are received. As stated in Attachment 4.19-D .0306 (e) (5) " The State may withhold up to twenty (20%) percent per month of a provider's payment for failure to file a timely cost report or other relevant information related to a facility's operation and requested by the Division of Medical Assistance". Please refer to your State Plan for complete procedure under Payment Assurances.

The provider assessment payment is recorded and deposited by the DHHS Controller's Office. One copy of the monthly assessment statement and copy of the check is forwarded to the Division of Medical Assistance, Rate Setting Section. Upon receipt, Rate Setting keys the payment information into a database for reporting and/or history. The DHHS Controllers Office will send a statement to the provider if the monthly assessment statement and payment do not balance. For the first month, providers with obvious errors or omissions will receive a courtesy call from DMA.

If you have any questions or concerns (including monthly assessment statement assistance and payment verification), please call the Division of Medical Assistance, Rate Setting section at 919-855-4200.

E. Instructions on how to compute the ICF-MR Non-State monthly provider tax assessment statement

These expanded instructions and explanations should be used to assist in the accurate completion of the Monthly Assessment Fee Statement.

- Provider Assessment is based on all ICF-MR non-Medicare Occupied bed days.

- Provider's Month End and Year End Totals (Occupied bed days) must agree with the provider's midnight census as well as with the year end cost report days.

1. Facility Name: Enter the ICF-MR Facility name as it appears on the intermediate care license. Enter the name consistently on each month's report.

2. Provider Number: Enter the ICF-MR Medicaid provider number.

3. Federal Tax ID Number: Enter the Federal Tax Identification number.

4. Total Medicaid Occupied Bed Days, Current Month Ended Total: Enter the number of ICF-MR occupied bed days or payable by North Carolina Medicaid through the ICF-MR reimbursement program for the current month based on dates of service (not including Piedmont days. Place these totals in block number 5).

5. Total Piedmont Medicaid Occupied Bed Days, Current Month Ended Total: Enter the number of ICF-MR occupied bed days payable by Medicaid through the ICF-MR reimbursement program for the current month based on dates of service for clients with a county of residents in the 5 Piedmont Area Counties.

6. Total Private Occupied Bed Days, Current Month Ended Total: Enter the number of any ICF-MR occupied bed days not paid or payable by Medicaid as an ICF-MR day for the current month based on date of service.

7. Total Occupied Bed Days, Current Month Ended Total: Add items 4, 5, 6, then enter the result here.

8. Total Medicaid Occupied Bed Days, Documented Prior Period Adjustments: Enter the net number of previously unreported Medicaid patient day adjustments from prior periods. These adjustments would include patient days classified as Medicaid days that have been reclassified to non-Medicaid days as well as days that were previously classified as non-Medicaid days that were reclassified to Medicaid days. This should not include any Piedmont Medicaid days.

9. Total Piedmont Medicaid Occupied Bed Days, Documented Prior Period Adjustments: Enter the net number of previously unreported Medicaid Occupied Bed day's adjustments from prior periods for clients with a county of residence in the 5 Piedmont Area Counties.

Example A:

Patient I was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient I was actually a private pay. These 10 days

should be reclassified from Medicaid to Private days. The Medicaid day's impact for this would be decease on 10 days (-10).

Patient II was originally classified as Piedmont Area Counties of resident for 2 days in the previous month. A determination has been made that those days should have been covered by non Piedmont Medicaid days. These 2 days should be reclassified from Piedmont Area Counties of resident Medicaid days to Non Piedmont Medicaid days. The Medicaid day's impact for this would be an increase of 2 days (+2).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be -8 (-10 plus +2).

A sample worksheet showing this example is attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include a FL-2 Medicaid Remittance Advice, or other official documentation.

10. Total Private Occupied Bed Days, Documented Prior Period Adjustments: Enter the number of previously reported Private patient day adjustments for prior periods. These adjustments would include patient days classified as Private days that have be reclassified to Medicaid as well as days that were previously classified as Medicaid days that need to be reclassified to Private days.

Example B:

Patient I was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient I was actually a private pay. These 10 days should be reclassified from Medicaid to Private days. The Medicaid day's impact for this would be increase on 10 days (+10).

Patient III was originally classified as Private Pay for 4 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 4 days should be reclassified from Private Pay to Medicaid. The Medicaid day's impact for this would be a decrease of 4days (-4).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be +6 (+10 plus 4).

A sample worksheet showing this example is attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include a FL-2 Medicaid Remittance Advice, or other official documentation.

11. Total Occupied Bed Days, Documented Prior Period Adjustments: Add items 8, 9, and 10 and enter the result here.

Example C:

Patient II was originally classified as Medicaid for 2 days in the previous month. A determination has been made that Patient II was actually a private pay. These 2 days should be reclassified from Medicaid to Private days. The Medicaid day's impact for this would be decease on 2 days (-2).

Patient III was originally classified as Private Pay for 4 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 2 days should be reclassified from Private Pay to Medicaid. The Medicaid day's impact for this would be an increase of 4 days (+4).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be +2 (-2 plus +4).

A sample worksheet showing this example is attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include a FL-2 Medicaid Remittance Advice, or other official documentation.

12. Total Medicaid Days, Adjusted Monthly Total: Add items 4 and 8 then enter the result here.

13. Total Piedmont Medicaid Occupied Bed Days, adjusted Monthly total: Add items 5 and 9 and enter the result here.

14. Total Private Occupied Bed Days, adjusted Monthly total: Add items 6 and 10 and enter the result here.

15. Total Occupied Bed Days, adjusted Monthly Total: Add items 12, 13, and 14, and then enter the result here.

16. Provider Assessment Daily Rate: This is the fixed $9.33 provider tax assessment as indicated on the cover letter that accompanied the reporting packet.

17. Monthly Provider Fee Due: Multiply item15 by item16 and enter the result here. This is the amount of assessment due on or before the 15th of the month following the reporting period. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan.

18. Total Medicaid Occupied Bed Days, Year to date Cumulative: Add item 12 from the current period report to item 18 from the previous period report and enter the result here.

19. Total Piedmont Medicaid Occupied Bed Days, Year to date cumulative: Add item 13 from the current period report to item 19 from the previous period report and enter the result here.

20. Total Private Occupied Bed Days, Year to date cumulative: Add item 14 from the current period report to item 20 from the previous period report and enter the result here.

21. Total Occupied Bed Days, Year to Date cumulative: Add items 18, 19, and 21 and enter the result here.

22. Signed by: Upon completion, this form must be signed by an Owner, Partner, Officer or Administrator of the reporting facility. If not signed, the form will be considered incomplete.

23. Date: Date of completion of statement

24. Print Name: Legibly print the name of the individual who signed the form.

25. Title: Title of the individual who signed the form.

26. Telephone: Enter the Telephone number of the individual who signed the form.

27. E-mail: Enter the e-mail address of the individual who signed the form.

NON STATE OWNED INTERMEDIATE CARE FACILITY MONTHLY ASSESSMENT FEE STATEMENT

Please Update All Shaded Fields For Each Monthly Assessment

Month End Assessment Date ***30-Apr-05***

STATEMENT DUE NO LATER THAN THE 15th OF **May-05**

Intermediated Care Facility Name: 1

Medicaid Provider Number: 2

Federal Tax Identification Number: 3

Please complete and return two copies of this form along with your monthly fee payment to the address below. It is imperative that you complete all shaded data fields on this statement. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan. Please contact DMA, Finance Management, Rate Setting Section, if you should have any questions regarding this form or the reporting requirements a (919) 855-4200

Please Make Check Payable to:
Division of Medical Assistance
(Please Write in the Memo Field

("ICF-MR Fee Assessment")

Mailing Address:
DHHS Accounts Receivable
2022 Mail Service Center
Raleigh, NC 27699-2022

ICF-MR Provider Assessment Worksheet FYE July 2004 - June2005

	Current Month Ended Total	Documented Prior Period Adjustments	Adjusted Monthly	Year to Date Cumulative FYE 07/1- 6/30
A. Total Medicaid Occupied Bed Days (less Piedmont Days)	4	8	12	18
B. Total Piedmont Medicaid Occupied Bed Days	5	9	13	19
C. Total Private Occupied Bed Days	6	10	14	20
D. Total Occupied Days (A+B+C+D)	7	11	15	21
E. Provider Tax Assessment Daily Rate			$9.33	(16)
F. Monthly Provider Fee Due(D)*E			17	

22
(Signed By: Owner, Partner, Officer or Administrator)

23
Date

23
Print Name

25
Title

26
Telephone Number

27
Email Address

ICF-MR Supplemental Calculation Worksheet for the Prior Period Adjustments

1. Complete the section for Patient Name and indicate the Dates of Service that are being adjusted.
2. Indicate how the adjusted days were classified prior to adjustment and after adjustment. Show the number of days below each payer source.
3. Add the amount in each column and enter the totals where indicated. The net days adjustments are calculated as indicated.

		As-filed (complete days as originally classified)			As-Adjusted (complete days as currently reclassified)		
Patient Name	Dates of Service	Medicaid Occupied Bed Days	PCR Medicaid Occupied Bed Days	Private Occupied Bed Days	Medicaid Occupied Bed Days	PCR Medicaid Occupied Bed Days	Private Occupied Bed Days
Example A	04/10/05 - 04/20/05	10	2		2	10	
Example B	04/25/05 - 04/27/05	10		4	4	10	
Example C	04/22/05 - 04/26/05	2	4		4		2
	Column Totals	22	6	4	10	20	2
		Total A	Total B	Total C	Total D	Total E	Total F

Example

Total Medicaid Patient Days, Documented Prior Period Adjustments = Total D - Total A	-12
Total PCR Medicaid Patient Days, Documented Prior Period Adjustments – Total E – Total B	14
Total Private/Other Non-Medicare Patient Days, Documented Prior Period Adjustments = Total F - Total C	-2

***PCR = Piedmont Counties of Residency**

F: The Auditing Assurances Process

The Division of Medical Assistance will compare and reconcile reports provided by the Controller's Office to the reports from DMA's database on a monthly basis. DMA will also validate amounts received from monthly statements vs. projected amounts based on drive run data Reports. The Division of Medical Assistance will maintain a database of all delinquent ICF-MR providers for audit trail and/or history. At SFYE DMA will provide the Audit Section with all database collections records totals for all ICF-MR providers to be used in the year end cost report review and cost settlement process. Provider's Assessment Fee Statement Month End and Year End Totals must agree with the provider's midnight census as well as with the year end cost report days.

G: Reference

DMA	Division of Medical Assistance
PBH	Piedmont Behavioral Health
SFY	State Fiscal Year
SFYE	State Fiscal Year End
DHHS	Department of Health and Human Services

5 Piedmont Counties:

- Cabarrus
- Davidson
- Rowan
- Stanly
- Union

You may obtain the complete State Plan for ICF-MR Attachment 4.19-D at
http://www.dhhs.state.nc.us/dma/plan/sp.pdf